

Michigan Family Independence Agency
Office of Children and Adult Licensing
Division Of Adult Foster Care Licensing
AFC – RESIDENT CARE AGREEMENT

This home is licensed by the Family Independence Agency to provide foster care to adults.

Name of Licensee	License Number	Type of AFC Home: (Check One) <input type="checkbox"/> AFC Family Home 1 - 6 <input type="checkbox"/> AFC Small Group Home 1 - 6 <input type="checkbox"/> AFC Small Group Home 7-12 <input type="checkbox"/> AFC Large Group Home 13 - 20
Name of Home	Address of Home	

INSTRUCTIONS:

- This form is to be completed at the time of a resident's admission.
- This form is to be completed by the licensee in cooperation with the resident or his/her designated representative and the responsible agency, if applicable.
- The care and services agreed upon are to be based upon the licensee's written assessment of the amount of personal care, supervision, and protection required by the resident.
- A copy of the signed Resident Care Agreement is to be provided to the resident or his/her designated representative, and the responsible agency, if applicable. A copy is to be maintained by the licensee in the resident's record.
- The Resident Care Agreement is to be reviewed at least annually or more often if necessary.

A. RESIDENT'S OR DESIGNATED REPRESENTATIVE SECTION:

Name of resident	
I have designated _____ (name of designated representative) to act as my representative (if applicable).	
_____ Resident Signature	_____ Date
1. I have received a copy of the house rules (if applicable). I have had the house rules explained to me, and agree to follow them. 2. I have received a copy of the Adult Foster Care Resident Rights and have had my rights explained to me. I understand that I have a right to voice grievances and present recommendations pertaining to the policies, services, and house rules of the home without fear of retaliation. 3. I agree to provide all personal and identifying information required by the rules. 4. I agree to provide or assist in providing a health care appraisal completed either within the 90 days prior to my admission or within 30 days after an emergency admission. (OCAL-3947 or an approved substitute is to be used)	
5. I agree to participate in the completion of a written assessment plan to determine my needs for foster care. Yes <input type="checkbox"/> No <input type="checkbox"/>	
6. a. I agree to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available. Yes <input type="checkbox"/> No <input type="checkbox"/> b. I do not normally require assistance in bathing, dressing, or personal hygiene, but agree to receive assistance by a staff member of the opposite sex should such assistance become necessary. Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. I agree to entrust the following to the licensee for safekeeping. (See page 3 for information regarding "funds" and "valuables")	
a. Funds: <input type="checkbox"/> Yes <input type="checkbox"/> No	b. Valuables: <input type="checkbox"/> Yes <input type="checkbox"/> No
8. I agree to have the licensee manage and account for financial transactions on my behalf. <input type="checkbox"/> Yes <input type="checkbox"/> No Expenditures of personal funds over the amount of \$ _____ require my prior written approval.	
9. I understand that this agreement constitutes the fee policy statement required by Family Home Rule 400.1407(11). <input type="checkbox"/> Yes <input type="checkbox"/> No	

10. Fees and Payment (Complete appropriate option):

a) I agree to pay the basic fee of \$ _____ (amount) to _____ (name) on a _____ (daily, weekly, monthly) basis for the services specified in my written assessment and this agreement.

b) For homes receiving contractual payments for cost of care and services, contractual payments will be paid by _____ (name of contractual services provider) per the contract with that agency.

11.(a) Additional Services to be Purchased

11.(b) Fee for Services

12. I have received a copy of the home's Refund Policy. I agree to accept the terms of the Refund Policy should discharge be necessary. (AFC GROUP HOMES ONLY)

☐ Yes ☐ No

13. I have received a copy of the home's Admission and Discharge Policy. I agree to follow the home's discharge procedures. (AFC GROUP HOMES ONLY)

☐ Yes ☐ No

B. LICENSEE SECTION:

Name of licensee _____

1. I have provided _____ (name of resident or designated representative) with a copy of:

- | | |
|--|---|
| a. The Adult Foster Care Resident Rights | <input type="checkbox"/> Yes (All Homes) |
| b. The House Rules/Guidelines (if established) | <input type="checkbox"/> Yes (All Homes) |
| c. The Admission and Discharge Policy | <input type="checkbox"/> Yes (AFC Group Homes Only) |
| d. The home's Refund Policy | <input type="checkbox"/> Yes (AFC Group Homes Only) |

2. I agree to provide personal care, supervision and protection in addition to room and board for 24 hours a day for this resident.

3. I agree to assure the availability of transportation services.

a. I agree to provide the following transportation services for the basic fee charged: _____

b. I agree to provide the following transportation services at an extra cost of \$_____ (List transportation services)

c. Transportation will be provided by other means (describe): _____

4. I agree to provide the additional services as stipulated in Section A.

5. I agree to provide this resident or designated representative with a 30-day written notice before discharging him or her from the home unless emergency discharge is necessary.

6.	I have explained to this resident or designated representative that emergency discharge may occur when it has been determined that any one of the following exists:
a.	Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well being of other residents of the home. (AFC Group Homes Only)
b.	Substantial risk or an occurrence of self-destructive behavior.
c.	Substantial risk or an occurrence of serious physical assault.
d.	Substantial risk or an occurrence of destruction of property.
7.	I agree to notify the resident, the resident's designated representative, and the responsible agency within 24 hours before emergency discharge.
8.	Group homes must meet additional discharge requirements. Emergency discharge is to be in accordance with the home's discharge policy. (Please refer to the Home's Discharge Policy for details.)
9.	I agree to discuss the possibility of relocation from this home to another with this resident or designated representative. I will obtain written approval from this resident or designated representative, and the responsible agency, if applicable, when relocation has been agreed upon.
10.	I agree to provide the following as specified in the resident's written assessment plan:
a.	Direction and opportunity for the growth and development of the resident which are achieved through activities which foster independent functioning, such as dressing, grooming, manners, shopping, cooking, money management, and use of public transportation.
b.	Opportunity for involvement in educational, employment, and day program opportunities.
11.	I agree to provide all of the following:
a.	Opportunity for the resident to develop positive social skills.
b.	Opportunity for the resident to have contact with relatives and friends.
c.	Opportunity for community-based recreational activities.
d.	Opportunity for privacy and leisure time.
e.	Opportunity for religious education and attendance at religious services of the resident's religious choice.
12.	I agree to handle resident funds as specified in the Resident Funds Part I form (OCAL-2318).
13.	(a) The residents incidental needs are as follows: _____ (please attach additional pages as necessary)
	(b) These incidental needs will be met as follows: _____ (please attach additional pages as necessary)
14.	I agree to accept the following for safekeeping*:
a.	Funds: <input type="checkbox"/> Yes <input type="checkbox"/> No
b.	Valuables: <input type="checkbox"/> Yes <input type="checkbox"/> No
15.	I agree to accept responsibility for the management and accounting of this resident's financial transactions. I recognize that I am prohibited from having any ownership interest in the resident's account. Neither I or my family members will accept, take, or borrow money or valuables from a resident nor will I allow this of my employees, their family members, or volunteers who are under my direction. <input type="checkbox"/> Yes <input type="checkbox"/> No
16.	I agree to maintain a trust fund account for this resident which will be kept separate and apart from all other accounts. I recognize that the amount of this trust fund account is not to exceed \$1,500.00. (The \$1,500.00 limit applies to AFC Family Homes Only.) <input type="checkbox"/> Yes <input type="checkbox"/> No
17.	I agree to supervise this resident's taking of his or her prescription medication unless otherwise indicated by a written statement from the resident's physician.

C. ADDITIONAL CONDITIONS: (Optional)

Resident: <hr/> <hr/> <hr/> <hr/>	
Licensee: <hr/> <hr/> <hr/> <hr/>	

D. SIGNATURES:

Resident:	Date
Resident's Designated Representative (If applicable)	Date
Licensee or Designee	Date
Responsible Agency (If applicable)	Date

E. ANNUAL REVIEW SIGNATURES: (ONLY IF THERE HAS BEEN NO CHANGE IN THIS AGREEMENT)

Resident:	Date
Resident's Designated Representative (If applicable)	Date
Licensee or Designee	Date
Responsible Agency (If applicable)	Date

*Funds on the premises of a group home cannot exceed \$200.00.

*Funds and valuables on the premises of a family home cannot exceed \$200.00.

*A trust fund account cannot exceed \$1,500.00. (Family Homes Only)

AUTHORITY: Act 218 of PA of 1979, as amended. COMPLETION: Mandatory PENALTY: Violation of Adult Foster Care Administrative Rule	The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA office in your county.
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